No differences in improvements in HRQoL were observed with epratuzumab during EMBLEM™, potentially due to short term treatment, small sample sizes and active SOC therapy. Sustained improvements were observed in the EMBLEM™ OLE, consistent with those in the ALLEVIATE RCTs.

PSY53

COMORBIDITIES, HEALTH-RELATED QUALITY OF LIFE AND PRODUCTIVITY LOSS ASSOCIATED WITH OBESITY

Gupta S[1], Wang Z[2], Pomerantz D[1]

[1]*Kantar Health, Princeton, NJ, USA,* [2]*Eisai Inc., Woodcliff Lake, NJ, USA*

OBJECTIVES: Obesity is associated with many health-related risk factors and is a significant economic burden on society. The objectives of this study were to examine the prevalence of patient-reported comorbidities, productivity loss and health-related quality of life (HRQoL) across different BMI ranges. **METHODS:** Overweight/obese patients from the 2012 U.S. National Health and Wellness Survey, a nationally representative, online survey of 71,157 respondents aged ≥18 years, were categorized and analyzed by their BMI: overweight (BMI>=25 & <30 kg/m^2), obese class I (BMI>=30 & <35 kg/m^2), obese class II (BMI>=35 & <40 kg/m^2), and obese class III (BMI>=40 kg/m^2). Patients provided information on HRQoL (SF-36v2: mental and physical component summary (MCS, PCS) and SF-6D (health utility) scores), productivity loss (Work Productivity and Activity Impairment questionnaire) and comorbidities (sleep-difficulties, insomnia, pain, anxiety and depression) they experienced in the past 12 months. **RESULTS:** Among 45,641 overweight/obese patients, 49.8% were overweight, 27.9% were obese class I, 12.5% were obese class II, and 9.8% were obese class III. The proportions of patients experiencing sleep-difficulties (overweight: 20.3%; obese class I: 24.6%; obese class II: 28.6%; obese class III: 35.3%), pain (overweight: 32.6%; obese class I: 38.1%; obese class II: 42.5%; obese class III: 48.5%), insomnia, anxiety and depression increased along with BMI increase (all p<0.001). MCS (overweight: 50.0; obese class I: 48.9; obese class II: 47.8; obese class III: 46.1), PCS (overweight: 51.1; obese class I: 48.8; obese class II: 46.5; obese class III: 43.0) and health utility scores declined with an increase in BMI (all p<0.001). Among employed patients, overall work impairment increased as BMI increased (p<0.001). **CONCLUSIONS:** Data suggests a greater prevalence of pain, depression, anxiety, and sleep problems as BMI increases. Increasing BMI is also associated with significantly worsening HRQoL. Successful obesity prevention and management may help improve patients' quality of life and productivity.

PSY54

BURDEN OF DISEASE IN SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS TREATED WITH CORTICOSTEROIDS

Strand V[1], Johnson J[2], Vandeloo C[3], Galateanu C[3], Lobosco S[2]

[1]*Biopharmaceutical Consultant, Portola Valley, CA, USA,* [2]*Adelphi Real World Ltd, Macclesfield, UK,* [3]*UCB Pharma, Brussels, Belgium*

OBJECTIVES: Current treatments for systemic lupus erythematosus (SLE) include corticosteroids (CS), immunosuppressants (IM), antimalarials (AM) and biologics. SLE treatments, in particular CS, are associated with adverse effects which impact tolerability and treatment-burden. This study sought to assess the use of CS in SLE, and the burden associated with this treatment class. **METHODS:** Data were extracted from the Adelphi 2013 Lupus Disease-Specific Programme (a multinational survey of clinical practice). Physicians completed Patient Record Forms (PRFs) and underwent face-to-face interviews; patients self-reported data including the EQ-5D, Work Productivity & Activity Impairment Index for SLE (WPAI-Lupus) and Functional Assessment of Chronic Illness Therapy-Fatigue (FACIT-F) in Patient Self-Completion Records (PSCs). Patient eligibility was determined by physicians; disease activity and severity were based on physician and patient assessment. **RESULTS:** Data were collected from rheumatologists in the US (n=97), France (n=37) and Germany (n=35), including PRFs (550/200/207, respectively) and PSCs (303/109/149, respectively). 57%/84%/89% of patients in the US/France/Germany were receiving CS treatment. CS were perceived to be equal/superior to AM, IM and biologics in the ability to rapidly treat flare and pain but inferior in terms of safety/tolerability and inhibition of disease progression. More than half of patients had concerns regarding CS treatment, mainly due to side-effects and fear of long-term use. Patients receiving CS had greater resource use (increased IM/biologic use, greater physician consultation and hospitalisation) and worse HRQoL and activity impairment vs non-CS patients (EQ-5D=0.78 vs 0.87; FACIT-F=34.41 vs 39.56; WPAI=23.30 vs 13.22), but were also associated with worse clinical status (more 'moderate severe' SLE, more 'deteriorating' disease state, more rash/pain/flaring/depression, greater organ system involvement). **CONCLUSIONS:** Although a major component of SLE standard of care, clear unmet needs are associated with CS use regarding HRQoL and resource use. Long-term safety and tolerability are also major areas of concern for both physicians and patients.

SYSTEMIC DISORDERS/CONDITIONS – Health Care Use & Policy Studies

PSY55

IMPACT OF BMI ON CHARGES AND REIMBURSEMENT IN KIDNEY TRANSPLANT HOSPITALIZATION OF DECEASED AND LIVING DONOR RECIPIENTS

Crow L[1], Tan Y[1], Cavanaugh TM[1], Heaton P[1], Diwan T[2], Succop P[1], Eckman MH[3], Irish W[4], Volek P[1], Boone J[1]

[1]*University of Cincinnati, Cincinnati, OH, USA,* [2]*University of Cincinnati- College of Medicine, Cincinnati, OH, USA,* [3]*University of Cincinnati Medical Center, Cincinnati, OH, USA,* [4]*CTI Clinical Trial and Consulting Services, Raleigh, NC, USA*

OBJECTIVES: Our objective was to determine costs of kidney transplant hospitalization in charges billed and payments reimbursed by Medicare based on body mass index(BMI). **METHODS:** Retrospective analysis of USRDS and Medicare Claims from 2004-2009 for primary Medicare beneficiaries of primary kidney transplant of deceased (DD) and living donors (LD) recipients. Subjects were excluded for multiple transplants, donor < 5 yo, and transplantation payment < 15,000 U.S. dollars. BMI was categorized according to WHO classifications. Total direct medical costs were assessed for transplantation in terms of charges and payments. Costs were standardized to 2012 U.S. dollars. Univariate analyses of covariates were assessed for association with log-transformed charges and payments and significant variables were included in multivariate regression analysis. Base charges and payments include covariates at mean values and based on low risk characteristics. **RESULTS:** In multivariate analysis, DD base charges at transplant were $155,906 (adjusted R2 0.314). BMI > 40 and BMI 35 – 39.9 was associated with an additional $13,3662 (p<0.0001) and $4,107 (p=0.005) at transplant, respectively. BMI 18.5 – 24.9 was attributed to significantly less charges of $2,168 (p=0.016). Base reimbursements at transplant were $36,315 (adjusted R2 0.229). Elevated BMI was not attributed at any additional reimbursements, however BMI 18.5 – 24.9 had additional reimbursements of $660 (p<0.0001). For LD, base charges were $151,291(adjusted R2 0.312) and BMI 30 – 35.9 was associated with an additional $3,675 (p=0.018) at transplant. Base reimbursements were $38,361(adjusted R2 0.239). Elevated BMI was not a significant independent factor additional reimbursement. **CONCLUSIONS:** Increased BMI is a significant factor in the amount of health resources utilized for kidney transplantation. While elevated BMI results in significant greater costs to hospitals, no additional reimbursement from Medicare was observed. These findings may play a factor in negative selection against candidates with higher BMI at the time of transplantation.

PSY56

PMSI DATABASE CONSULTATIONEVALUATION OF HOSPITAL STAY LENGTH FOR INFANTILE HAEMANGIOMA IN FRANCE PREVIOUS TO AND SUBSEQUENT TO PROPRANOLOL USE

Taieb C

CréeS, Paris, France

OBJECTIVES: Infantile haemangioma (IH) appears in the first few days of life, and develops over time. Certain types of IH cause significant functional impairment and aesthetic. The objective of this work was to estimate (in children under the age of two years) hospital stay length for IH previous to and subsequent to introduction of propranolol as haemangioma treatment. **METHODS:** Analysis of the PMSI database covered two periods: the first previous to propranolol use (2006) and the second more recent (2011) during which use of propranolol became widespread. In the PMSI database, haemangioma can be found under primary diagnosis (or related) or associated, it is normal to carry out economic assessments on the PD. **RESULTS:** In 2006, 1,205 children were admitted to hospital for IH, thus generating 1,758 hospital stays. Day hospital admissions represent 24%. In 2011, 1,712 children were admitted to hospital for IH, thus generating 2,136 hospital stays,. Day hospital admissions represent 30%. The average length of stay, with haemangioma as primary diagnosis, decreased from 2.44days in 2006 to 1.16days on average in 2011, representing a 50% decrease. We note that DRG differ between 2006 and 2011, suggesting that the diagnosis is best determined. **CONCLUSIONS:** Infantile haemangioma has a significant medical and financial impact. A recent assessment conducted in France in five hospitals treating IH, considered that the average cost of treatment (according to the health insurance fund) of children with haemangioma reached €6,407.00 on average. The highest expenditure item was hospitalisation at an average cost of €5,337.00 (equivalent to 83% of the total average cost). A reduction in the length of hospital stays, subsequent to propranolol use, of almost 50% as demonstrated by the PMSI, should have a significant effect on treatment costs.

PSY57

INITIATION OF PRESCRIPTION OF BIOLOGICS FOR PATIENTS WITH PSORIASISPROFILE OF PATIENTS AND PRESCRIBING PROVIDERS

Li Y[1], Liao M[2], Arcona S[1]

[1]*Novartis Pharmaceuticals Corporation, East Hanover, NJ, USA,* [2]*KMK Consulting, Inc., Florham Park, NJ, USA*

OBJECTIVES: Psoriasis (PsO) is a chronic, recurrent, immune-mediated disease often treated with biologic therapies. However, understanding of prescription initiation of biologics for psoriasis is limited. The current study evaluates patient and provider characteristics in treatment-naïve PsO patients prescribed either exclusively oral or biologic-containing regimens. **METHODS:** A retrospective database analysis was performed using Humedica electronic medical record data for adult patients with at least one diagnosis for PsO and no prior history of PsO or PsO-related therapy within 12 months prior to index date. Eligible patients were classified based on initial prescription as (1) oral only or (2) biologics (including oral and biologics as combination treatment). Patients' demographic characteristics, comorbidities, disease status, prescriber specialty, and prescriber preference of biologics were compared for across both groups. Wilcoxon rank-sum and chi-squared tests were applied to variables of ordinal and nominal measure, respectively. Logistic regression was conducted to determine the variables associated with likelihood of initiation of a biologic treatment. **RESULTS:** A total of 2,373 patients met inclusion criteria. Of these patients, 1,166 (49%) were classified as obese, 856 (36%) were diagnosed with psoriatic arthritis (PsA) and 261 (11%) were diagnosed with rheumatoid arthritis (RA). Male patients (OR=1.47) and patients with comorbid PsA (OR=1.51) were significantly more likely to be prescribed biologics compared to female patients and those without comorbid PsA, respectively. However, older patients (≥65 years) were significantly less likely (OR=0.47) to be prescribed biologic regimens than patients aged 18-44 years. Differences in prescribing patterns by race, BMI, comorbid RA, and provider specialty were statistically insignificant. **CONCLUSIONS:** Male gender and comorbid PsA were associated with increased likelihood of initial biologic-based treatment for newly diagnosed PsO patients. Older age (≥65 years) was associated with a decreased likelihood of initial treatment with a biologic-containing regimen.

PSY58

ORPHAN DRUG POLICIES: LOOKING BACKWARD, THINKING FORWARD

Tavella F[1], Korchagina D[2], Belgaied W[3], Toumi M[4]

[1]*Creativ-Ceutical, London, UK,* [2]*Creativ-Ceutical, Paris, France,* [3]*Creativ-Ceutical, Tunis, Tunisia,* [4]*University Claude Bernard Lyon 1, Lyon, France*